REGISTRATION

FACILITY: REDOAK HOSPITAL, 17400 Red Oak Dr, Houston, Tx Tel: (281)919-1712 Fax:(832)446-9661

Date 3-18-14 Home Phone [redacted] Work Phone [redacted] Email _____
Patient Last Name [redacted] First Name [redacted]
Street Address [redacted]
City Spring [redacted] State Texas Zip 77373
Sex ☑ M ☐ F Age [redacted] Birth date [redacted] ☐ Single ☑ Married ☐ Widowed ☐ Separated ☐ Divorced
Social Security # _____ Driver's License # [redacted]
Insured Name [redacted] How and where did you learn about this Hospital [redacted]
Last Name First Name Initial

Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other
Condition/ Illness Related To ☐ Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER
Company Name AT+T Occupation outside Tech
Address Laredo St. Phone _____ ☐ Full-time ☐ Part-time
City Houston State TX Zip _____ Years Employed 40

INSURED INFORMATION
Name _____ Birthdate _____ SSN: _____
Last Name First Name Initial
Employer Na [redacted] Years Employed _____
Address _____ Phone _____ Occupation _____
City _____ State _____ Zip _____ ☐ Full-time ☐ Part-time

PATIENT INSURANCE INFORMATION
Please list any and all insurance and/or employee health care plan coverage you or your spouse may have
Insurance Company or Health Care Plan Name United Healthcare
Policy/Group #: _____ Effective Date: _____
Name of Insured: [redacted] ID #: _____

SPOUSE COINSURANCE INFORMATION
Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have
Insurance Company or Health Care Plan Name _____
Policy/Group #: [redacted] Effective Date: _____
Name of Insured: [redacted] ID #: _____

MEDICAL AND LEGAL INFORMATION
Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐ Yes ☑ No Your Initials: PM
If you answered yes, please fill out accident specific form, available at the front desk.
Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician _____
Person to contact in emergency (Name and Phone #) _____
Attorney _____ Telephone: _____
Address _____

Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws

Legal Assignment Of Benefits And Designation Of Authorized Representative

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the law to [illegible] benefits, settlement, insurance reimbursement and any applicable reme [illegible] information about the claim to the same extent as the assignor; (2) subr [illegible] or law; (4) making any request, or giving, or receiving any notice about [illegible] judicial actions by such provider(s) to pursue such claim, chose in ac [illegible] group health plan(s), including, if necessary, bring suit by such prov [illegible] group health plan in my name with derivative standing but at such prov [illegible] is valid for all administrative and judicial reviews under PPACA, ERISA [illegible] applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

[redacted] LOC: OH
ADMIT: 03/18/14
ADM: SOKHON KOZHAYA
MR# 100304 VISIT #: 2562

[redacted] 3-18-14
Signature of Insured / Guardian Date

291624

REGISTRATION

FACILITY: REDOAK HOSPITAL, 17400 RedOak Dr, Houston,Tx Tel: (281)919-1712 Fax:(832)446-8961

Date 2-5-19 Cell Home Phone [redacted] Work Phone _____ Email [redacted]
Patient Last Name [redacted] First Name [redacted] Initial D
Street Address [redacted]
City Houston State TX Zip 77067
Sex (M) (F) Age [redacted] Birth date [redacted] Single (Married) Widowed Separated Divorced
Social Security # [redacted] Driver's License # [redacted]
Insured Name [redacted] How and where did you learn about this Hospital? _____
Last Name First Name Initial
Relationship To Insured Self Spouse Child Other
Condition/ Illness Related To Illness Employment Auto Other

EMPLOYER	Company Name _____ Occupation _____ Address Retired Phone _____ Full-time Part-time City State Zip Years Employed
SPOUSE (PARENT)	Name [redacted] Birthdate [redacted] SSN: [redacted] Last Name First Name Initial Employer Name Double Years Employed _____ Address _____ Phone _____ Occupation _____ City State Zip Full-time Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name United Health Care Policy/Group #: 122266 Effective Date: _____ Name of Insured: [redacted] ID #: 845 777754
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name _____ Policy/Group #: _____ Effective Date: _____ Name of Insured: _____ ID #: _____
MEDICAL AND LEGAL INFORMATION	**Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for?** ☐ Yes ☐ No Your Initials: _____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant Yes (No) Pacemaker Yes (No) Family Physician [redacted] Person to contact in emergency (Name and Phone #) [redacted] Attorney _____ Telephone: _____ Address
Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws	**Legal Assignment Of Benefits And Designation Of Authorized Representative** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable r ining information about the claim to the same extent as the assignor; (2) [redacted] 2014-02-05 facts or law; (4) making any request, or giving, or receiving any notice a and judicial actions by such provider(s) to pursue such claim, chose R196047 oyee group health plan(s), including, if necessary, bring suit by such 1952-08-19 291627 oyee group health plan in my name with derivative standing but at such nent is valid for all administrative and judicial reviews under PPACA, l 's. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. [redacted] 2-5-14 Signature of Insured / Guardian Date

REGISTRATION

FACILITY: REDOAK HOSPITAL, 17400 RedOak Dr, Houston,Tx Tel: (281)919-1712 Fax:(832)446-9661

Date 1-8-14 Home Phone [redacted] Work Phone ____ Email ____

Patient Last Name [redacted] First Name [redacted] Initial ____

Street Address [redacted]

City Spring State Texas Zip 77388

Sex ☒M ☐F Age [redacted] Birth date [redacted] ☐Single ☒Married ☐Widowed ☐Separated ☐Divorced

Driver's License # [redacted]

Social Security # [redacted]

Insured Name [redacted] How and where did you learn about this Hospital [redacted]

Last Name First Name Initial

Relationship To Insured ☐Self ☒Spouse ☐Child ☐Other

Condition/ Illness Related To ☐Illness ☐Employment ☐Auto ☐Other

EMPLOYER

Company Name ____ Occupation ____

Address ____ Phone ____ ☐Full-time ☐Part-time

City ____ State ____ Zip ____ Years Employed ____

SPOUSE (PARENT)

Name ____ Birthdate ____ SSN: ____

Last Name First Name Initial

Employer Name ____ Years Employed ____

Address ____ Phone ____ Occupation ____

City ____ State ____ Zip ____ ☐Full-time ☐Part-time

PRIMARY INSURANCE INFORMATION

Please list any and all insurance and/or employee health care plan coverage you or your spouse may have

Insurance Company or Health Care Plan Name United Health care

Policy/Group #: 722266 Effective Date: ____

Name of Insured: [redacted] ID #: 844198299

SECONDARY COINSURANCE INFORMATION

Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have

Insurance Company or Health Care Plan Name ____

Policy/Group #: ____ Effective Date: ____

Name of Insured: ____ ID #: ____

PATIENT MEDICAL INFORMATION

Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐Yes ☒No Your Initials: ____

If you answered yes, please fill out accident specific form, available at the front desk.

Pregnant ☐ Yes ☐ No Pacemaker ☐Yes ☐No Family Physician ____

Person to contact in emergency (Name and Phone #) ____

Attorney ____ Telephone: ____

Address ____

Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws

Legal Assignment Of Benefits And Designation Of Authorized Representative

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable emplo... insurance policies or liability claim, any claim, chose in action, or other right I may have to suc... tortfeasor insurer(s) under any applicable insurance policies, emplc... o medical expenses incurred as a result of the medical services I receiv... l extent permissible under the law to claim or lien such medical benef... plicable remedies, including, but not limited to, (1) obtaining infor... gnor; (2) submitting evidence; (3) making statements about facts or law, (4) ... notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

[redacted] 2014-01-10
R19602495
1952-01-28 288606

X [redacted] 1-8-14

Signature of Insured / Guardian Date